Chapter XI. *Behavioral Health: Mental Health, Alcohol, Other Drugs, and Tobacco*

Introduction. The original directive from SHPDA called for the creation of two separate chapters:

- Chapter X. would address ***Mental Health***.
- Chapter XI. would address ***Substance Abuse: alcohol, tobacco and other drugs.***

Each chapter would be divided into two sections – one for Adults, and the other for Children and Adolescents.

We began the development of each chapter by soliciting community feedback using a mental health and substance abuse survey. The survey questions targeted the identification of population(s) at risk, key service or treatment indicators that could be measured, and perceived barriers to care. The survey audience was primarily members from the seven SHPDA Sub-Area Councils (SACs). We also met with members from the Provider and Payer community. From the combined feedback, several common themes emerged:

- People find it difficult to separate substance abuse from mental health, finding *behavioral health* a more 'common' categorization even though many mental conditions are not considered 'behavioral'.
- The interaction of family intervention and support is significant with *behavioral health* issues; we cannot exclusively address issues of the patient.
- Integration of *behavioral health* with communicable diseases and chronic medical conditions is needed, with greater focus on prevention.
- *Behavioral health* illnesses are highly integrated with a social service(s) component.
- The chapter should adopt a broader definition of 'mental health' which encompasses both wellness and illness concepts.

As a result, we merged the original two chapters – Mental Health and Substance Abuse: alcohol, tobacco and other drugs – into a single chapter, entitled *Behavioral Health,* and have not presented separate sections on adult and children/adolescent issues.

We realize that this does not reflect the state-of-the-practice in Hawai`i where three separate State Department of Health divisions exist: Adult Mental Health (ADMH), Child and Adolescent Mental Health (CAMHD), and Alcohol and Drug Abuse (ADAD). However, perpetuating this separation is not deemed to be beneficial for the well-being of Hawai`i's citizens in need of behavioral health care. We hope that this *behavioral health* presentation will strengthen the collaboration among behavioral health policy-makers and providers.

A. OVERVIEW

Behavioral health illnesses are probably the most misunderstood, stigmatized disorders in healthcare. Its victims are universally underserved and misdiagnosed and are denied, missed, or dismissed from adequate treatment.

The scope of behavioral health illness is significant as these diseases affect all ethnic, economic, gender, age and geographical subsets of our population. Services that are developed to address behavioral health needs must be culturally diverse in the broadest sense of the term 'culture'.

Alcohol, drug abuse, and mental illness are extremely costly to society in terms of health, productivity, and crime. The National Association of State Alcohol and Drug Abuse Directors estimated that the economic cost of alcohol and other drug use in 1990 was a combined $165.496 billion nationally. The U.S. Department of Health and Human Resources, 1992, reported that the cost of mental illness doubled in the five year period between 1987 and 1992, from $150 billion to $300 billion in the U.S. These figures do not include the incalculable human costs in pain and suffering of those with these disorders, their loved ones, and the community.

The following sub-sections present an overview of the environmental climate for behavioral health services. Some national and Hawai`i prevalence data are presented, we identify at-risk populations, and there is a discussion of the behavioral health spectrum of care and the influence of the two consent decrees on services.

For more complete data and in-depth discussions of services for the public client, the reader may want to obtain the most recent state plans from the Department of Health's AMHD, CAMHD, and ADAD.

1. Selected Prevalence Data on Behavioral Health Related Illnesses. These data were selected to impress upon the reader the scope and pervasiveness of behavioral health problems in our community. The first chart summarizes the interrelationship of mental illness and substance abuse/addiction; the subsequent chart presents citations specific to alcohol, other drugs, mental illness, and tobacco.

(Continued next page.)

Estimated Annual Prevalence of Behavioral Health Problems in the United States
(Ages 1 - 54), National Co-morbidity Study, 1990 and 1992, University of Michigan[1]

Behavioral Health Problems	Prevalence (%)	No. of People (millions)
All behavioral health problems (i.e. mental disorders, alcoholism, and drug addiction)	29.5	52
Any mental disorder	22.9	40
Any substance abuse or dependence	11.3	20
Both mental disorder and substance abuse or dependence	4.7	8

Prevalence of Selected Behavioral Health Problems

Behavioral Health Problems	U.S. Prevalence No. of People	Hawai`i Prevalence No. of People
Severe mental illness[2]	5.5 Million	16,148
Child and adolescent mental disorders; Serious Emotional Disturbances (SED)[3]	7.7 to 12.8 million; fewer than 20% with SED receive early intervention	18,950 with mental disorders; up to 37,000 with additional special education needs
Phobias[4]	16.2 million	
Major Depression	6.4Million	
Obsessive-Compulsive Disorder	2.9 million	
Schizophrenia	1.8 Million	7,950
Panic Disorder	1.9 Million	
Manic depression or Bipolar disorder	1.1 million	8,198
In 1995, American public high school students reporting consideration of suicide and those having made an attempt during last year[5]	24%	26%
	9%	13%
Nursing home residents with mental disorder	66.5% of all residents	
Depression with chronic illness:[6]		
Coronary heart disease	40-65% of all patients	
Stroke survivors	10-27% of all patients	
Diabetics with complications	70% of all patients	
AIDS-related cognitive dysfunction	25% of all patients	
Neuropsychiatric problems HIV/AIDS patients[7]	66.5% of all patients	
Serious mental illness among homeless[8]	33.3% of all homeless people	

Behavioral Health Problems	U.S. Prevalence No. of People	Hawai`i Prevalence No. of People
Mental disorders within prisons		
Those routinely held without criminal charges[9]	1 in every 14 jail inmates 29% of all mentally ill inmates	
Students, grades 6-12, in need of alcohol/other drug treatment[10]		8,437 (9.8%)
Students, 6th and 8th grades, users of alcohol, cigarettes, other drugs[11]		Doubled between 1989 and 1996
American public high school seniors reporting ever trying marijuana and reporting use within last 30 days in 1996[12]	45% 22%	45% 25%
Adults in need of alcohol/other drug treatment[13]		In 1996, 79,119 adults needed treatment, of which 26,130 were women
Teen Smokers/all grades[14]	15% national average	22.8% Caucasians 32.8% Hawaiians
High school seniors reporting smoking in last 30 days[15]	34%	28%
Americans reporting current tobacco smoking in 1995[16]	22%	18%
Crime/alcohol & drug use:[17]	% of all crimes:	
Aggravated assault	40.4%	
Robberies	26.4%	
Spousal Abuse	50%	
Traffic fatalities	48%	
Simple assaults	31%	
Rape	45.3%	
Murder or manslaughter	33.2%	

**2. At-Risk Populations for Behavioral Health-Related Illnesses as Identified by Hawai`i's Communities.** Although behavioral health problems are not specific to any sub-set of our population, during the mid-1990's Hawai`i communities, primarily through the Sub-Area Councils (SAC), identified specific at-risk populations for whom behavioral health services were perceived to be more needed.

Big Island	Individuals with a dual diagnosis (mental illness and substance abuse); the uninsured; the poor and in-poverty; kids; elderly; unemployed (Hawai`i County SAC 1994).
Kaua`i County	Prison population needing treatment; 15% uninsured residents of Kauai; survivors of hurricane `Iniki who experience depression and suicide Seniors, homeless, substance abusing children, individuals with special needs (e.g., developmentally disabled, limited intellectual

functioning brain trauma victims). (Kauai County SAC 1996).

- Maui County — Perpetrators and victims in child abuse cases; individuals already identified by CAMHD, AMHD, and ADAD as 'at risk'—e.g. the homeless, some with communicable diseases such as AIDS, Native Hawaiians, those institutionalized (correctional, state hospital, youth facilities); high-risk adults in more remote areas; those with history of family violence, depression and suicide, chronically mentally ill, veterans. (Tri-Isle SAC, 1998)
- Oahu — Drug babies being born; uninsured; homeless; unemployed youth/school dropouts; poor/disadvantaged families, teens who use substances, including tobacco (Windward Oahu SAC 1998).
- Wai`anae — Residents receiving Medicaid and/or Medicare; those who are illiterate. (Wai`anae Coast SAC 1998).

The State Department of Health's divisions, although having to address multiple at-risk populations, have identified some targeted groups. The Alcohol and Drug Abuse Division has identified women of childbearing age and individuals involved in the criminal justice system as underserved at-risk populations. The Adult Mental Health Division has targeted individuals being discharged from the State Hospital for community-based services, whereas the Child and Adolescent Mental Health Division considers youth that the school system has identified as troubled as a primary at-risk population.

Each Island and each DOH division, in identifying its at-risk populations, consistently has requested more behavioral health services for its community, and identified a need for support services with which those providers can link for adequate, culturally appropriate service delivery.

3. Services and Continuum of Care. A full continuum of care for behavioral health services traditionally includes the following settings of care:

> acute, residential, therapeutic foster care, crisis shelter, medical and social detoxification, therapeutic living programs, partial hospitalization/day treatment, outpatient treatments (intensive, routine, in-school, in-home), clubhouses, and methadone/LAAM maintenance;

and a myriad of support services including:

> care coordination, identification and early intervention, prevention, crisis outreach, and opportunities for independent/supportive living, vocational placements, food banks, wellness training, family support services, and such.

It is important to note that support services are not detailed in this chapter, but the need for providers of behavioral health care to address and link with such services is a quality measure and should be mandatory.

Hawai`i's behavioral health community continues to identify an adequate and comprehensive continuum of care as a need.[18] It is generally perceived that the incidence of behavioral

health illnesses today far exceeds Hawai`i's capacity to provide adequate treatment statewide. Some of this most likely has to do with the lack of public funding and limited insurance coverage for these diseases.

Despite efforts made by the Department of Justice and the Department of Health in recent years to enhance mental health and substance abuse services throughout the state, Hawai`i remains deficient in providing an effective, full continuum of behavioral health care easily accessed by its people. Hawai`i has unique demographic attributes that often encumber these efforts, not the least of which include: it is the only state in the union that is made up of all island counties; it has a small population and a limited human resource pool available; and its insufficient community infrastructure on some islands precludes high quality, easily accessible, economically efficient care.

Hawai`i has been under two federal Consent Decrees for the past several years. The Felix v. Waihe`e, 1994 consent decree provides that the plaintiff class—all children and adolescents residing in Hawai`i, 0 to 20 years of age, who are in need of education and mental health services—receive a free appropriate public education, as required under IDEA and Section 504 of the Rehabilitation Act, and that a system of care that includes a continuum of services, programs, and placements, following the principles of the Child and Adolescent Service System Program (CASSP), be provided by June 30, 2000. The second consent decree is designed to bring the Hawai`i State Hospital in compliance with a 1991 settlement between the U. S. Justice Department and the State. In 1995, the federal court found the State in contempt for not living up to the terms of the 1991 agreement and approved a $6.9 million plan to improve conditions at the hospital. The hospital remains under court monitor.

Behavioral health practices in Hawai`i today are moving toward the goals and objectives of both decrees and overall improvement. The three State divisions—ADAD, AMHD, and CAMHD—and the consent decrees all concur that a full spectrum of care should be made available to all residents. All services do not necessarily need to be located within each community, as this would not be cost-efficient, but definitely services should be accessible by all. More fully developed community-based, outpatient service levels that foster continuity of care are crucial to building an effective behavioral health system of care for both adults and adolescents. Add to these directions a focus on collaboration among providers and continuous quality improvement, and Hawai`i will have a behavioral health system of care which will not only satisfy the existing consent decrees, but will eliminate the need for any further federal intervention. Of course expansion and addition of service levels can occur only with adequate public and private resources—a difficult barrier to overcome with the present economic situation in Hawai`i.

4. Trends. A few national trends should be noted as Hawai`i plans for additional behavioral health services:[19]

- There is an increase in the percentage of women seeking alcohol and other drug (AOD) treatment.
- There is a gradual aging of clients in AOD treatment, with the percentage of those 18-24 years old decreasing and those 35-44 increasing.
- Individuals seeking AOD treatment tend to have both alcohol and drug problems.
- Hawai`i's mandated "Mental Health and Alcohol and Drug Abuse Treatment Insurance Benefits" (§431M, HRS) suggests limited benefits by stating: "the insurance policy

may limit the number of treatment episodes but may not limit the number to less than two treatment episodes per lifetime."
- Managed behavioral health care is shortening lengths of stay at the acute levels of care and increasing utilization of outpatient services.

And a few trends specific to Hawai`i include:

- Individuals with both a mental illness and addiction problem are being identified in greater numbers.
- The use of ICE (methamphetamine) in Hawai`i challenges treatment providers to develop methodologies specific to the characteristics of this population of substance abusers.
- The refusal by many to accept beer as alcohol or marijuana as harmful presents both a prevention and treatment challenge.
- The economic uncertainty and the increasing population negatively impacts the 'mental and behavioral wellness' of our Hawai`i community.
- We are unlike many states in so far as 94% of Hawai`i's population is provided health care coverage. This extensive degree of coverage is a direct result of Hawai`i's Prepaid Health Act which mandates heath insurance coverage for any employee who works a minimum 20 hours per week, for four consecutive weeks.
- Hawai`i's mandated (§431M, HRS) Mental Health Substance Abuse Benefit is limited in that the substance abuse treatment benefit is limited to two treatment episodes per lifetime.
- Providing behavioral health care in Hawai`i is challenging. The QUEST program (Medicaid managed care) of Department of Human Services (DHS), AMHD, ADAD, CAMHD, the VA, Judiciary, and private insurance companies are all purchasers of service with different rates, different reporting requirements and different quality expectations.

B. Performance Measures/Indicators

Healthy People 2000 and the DOH divisions responsible for behavioral health have set indicators and outcome goals worthy of note; we have chosen to repeat only a select few of them in this document. (The reader is referred to Appendix ... for measures from *Healthy People 2000* and to the State Plans from the Adult Mental Health Division, the Child and Adolescent Mental Health Division, and the Alcohol and Drug Abuse Division.)

National accreditation bodies expect entities to excel not only in operations management but also in service delivery practices; receipt of JCAHO, CARF, or other national accreditation usually denotes a level of quality of care being maintained by the provider. Standards of operations and care required by these national accreditation bodies are not repeated here. Behavioral health entities providing managed care also fall under national scrutiny through NCQA and HEDIS requirements; these requirements are not included here.

What is included in the *Process Measures* are a few performance measures/indicators that Hawai`i applicants for new or expanded behavioral health services should address in their applications.

1. Process Measures

Measure Number	Monitor	Definition	Guideline	Hawai`i Experience	Guideline/ Hawai`i Experience Source	Cross Reference
BHP-1	Comprehensive Spectrum of Care	Defined within the State Plans of ADAD, AMHD, CAMHD	Refer to State Plans AMHD, CAMHD, ADAD	To Be Updated by SHCC's PDC	AMHD Plan, ADAD Plan, CAMHD Plan/CASSP document	
BHP-2	Continuity of Care	Extent to which collaborative agreements are in place among behavioral health providers to assure continuity of care and	To Be Updated by SHCC's PDC	none to date		*Infectious Diseases; Cancer; Diabetes and Other Chronic Disabling Conditions; Heart Disease*

Measure Number	Monitor	Definition	Guideline	Hawai`i Experience	Guideline/ Hawai`i Experience Source	Cross Reference
		linkage with community resources				*and Stroke; Preventable Injury and Violence; Maternal, Infant and Child Health*
BHP-3	Accessibility of Services	Extent to which a new service provider addresses geographical, reading/speak-ing/hearing challenges, physical challenges, and mental challenges of the population to be served	To Be Updated by SHCC's PDC	some information available through DHS since included in QUEST RFPs; To Be Updated by SHCC'S PDC		
BHP-4	Disease Management	Extent to which behavioral health practices are incorporated within medical care, specifically chronic disease management	Kaiser (CA) is presently researching the efficacy of this approach; To Be Determined	Hawai`i Biodyne demonstrated the efficacy of this approach in a research project @ 1987; To Be Updated by SHCC's PDC		*Cancer; Diabetes and Other Chronic Disabling Conditions; Heart disease and Stroke; Preventable Injury and*

Measure Number	Monitor	Definition	Guideline	Hawai`i Experience	Guideline/ Hawai`i Experience Source	Cross Reference
						Violence; Maternal, Infant and Child Health
BHP-5	Prevention	Extent to which health care providers heighten educational outreach to enhance behavioral health problem recognition and early treatment.	To Be Updated by SHCC's PDC	To Be Updated by SHCC's PDC		*Cancer; Diabetes and Other Chronic Disabling Conditions; Heart disease and Stroke; Preventable Injury and Violence; Maternal, Infant and Child Health*

2. Outcome Measures

Healthy People 2000 and the DOH Divisions responsible for behavioral health have set indicators and outcome goals worthy of note. We are not going repeat all of these in this section, but have re-stated some of those which are universally used at community and program levels to measure effectiveness of a behavioral health system of care.

Measure Number	Monitor	Definition	Guideline	Hawai`i Experience	Guideline/ Hawai`i Experience Source	Cross-Reference
BHO-1	Incidence/ Prevalence of Substance Abuse	% of adults having five or more drinks on an occasion, one or more times in past month	14% for year 2000 12% for year 2010	15% in 1993 12.4% in 1995	Healthy People 2000/DOH Office of Health Status Monitoring	*Preventable Injuries and Violence*
		% of high school seniors and young adults 18-24 having five or more drinks on an occasion in the previous two weeks	28% per year high school seniors for year 2000 32% per year for young adults 18-24 for year 2000	24.4% in 1993 25.2% in 1995 20.6% in 1993 18.1% in 1995		
BHO-2	Incidence/Prevalence of Substance Abuse	% adults who report having 60 or more drinks a month (an average of two or more drinks a day)	3.5% for year 2000 3.25% for year 2010	5.0% in 1993 3.0% in 1995	Healthy People 2000/DOH OHSM	*Preventable Injuries and Violence*

Measure Number	Monitor	Definition	Guideline	Hawai`i Experience	Guideline/ Hawai`i Experience Source	Cross-Reference
		% of young people who have used alcohol in the past month	12.6% age 12-17 29% age 18-20	38.4% in 1993 40.9% in 1995		
BHO-3	Medical Risk for Pregnant Women	Alcohol use by pregnant women Tobacco use by pregnant women Drug use by pregnant women	1.0% in Y2000 9.0% in Y2000 8.55% in Y2010 9.0% in Y2000 8.5% in Y2000	1.4% in 1994 18.3% in 1996 9.6% in 1994 10% in 1995 12.7% tested + in 1996 for illegal drugs	Healthy People 2000/ 1996 data from Blind Study conducted by DOH ADAD	*Maternal, Infant and Child Health; Preventable Injuries and Violence*
BHO-4	Mortality	Reduce deaths caused by alcohol-related crashes; cirrhosis; and drug-related deaths	<5.5/ 100,000 <6/100,000 <3/100,000	To Be Updated by SHCC's PDC	Healthy People 2000	*Preventable Injuries and Violence*

Measure Number	Monitor	Definition	Guideline	Hawai`i Experience	Guideline/ Hawai`i Experience Source	Cross-Reference
BHO-5	Incidence/ Prevalence of Mental Illness	Reduce: suicides; suicide attempts by adolescents; prevalence of mental disorders among adolescents; among adults living in community	<10.2 per 100,000 <59.5 per 100,000 <17% <10.7%	To Be Updated by SHCC's PDC 13% in 1995 To Be Updated by SHCC's PDC To Be Updated by SHCC's PDC	Healthy People 2000/ 1995 data from the *Youth Risk Behavior Report*	*Maternal, Infant and Child Health; Preventable Injuries and Violence*
BHO-6	Consumer Satisfaction	Consumers report satisfaction with access, coordination, thoroughness of care, communication, recovery	>80% level of satisfaction reported	HEDIS, Provider Surveys—To Be Updated by SHCC's PDC	FAACT	
BHO-7	Relapse/ Recidivism	% of individuals involved in acute or residential behavioral health treatment program who	To Be Updated by SHCC's PDC	To Be Updated by SHCC's PDC		

Measure Number	Monitor	Definition	Guideline	Hawai`i Experience	Guideline/ Hawai`i Experience Source	Cross-Reference
		return to that level of care (or a more intense level) within one year from discharge				
BHO-8	Positive Involvement After Treatment Program	% of individuals competing a formal treatment program who remain involved in aftercare sessions, self-help groups, and have no criminal involvement after one year from program discharge	To Be Updated by SHCC's PDC	To Be Updated by SHCC's PDC		

C. Community Specific Issues

Hawai`i communities, primarily through SAC representatives, have perceived the gaps in their community's behavioral health continuum of care to be as follows[20]:

- Big Island:
  - Outpatient services for individuals with dual diagnosis,
  - Medical detoxification,
  - Adequate crisis system (including beds),
  - School-based and community-based substance abuse prevention,
  - Children's school-based and home-based services for behavioral health.
- Kauai:
  - Access to all levels of behavioral health care,
  - Mental health services for less severe mentally ill and acute cases,
  - Crisis stabilization,
  - Mental health services for children and adolescents,
  - Substance abuse spectrum of care for all ages.
- Maui County:
  - Easy/assisted access to behavioral health services for residents of three Islands,
  - Detoxification services,
  - Outpatient services for individuals with dual diagnosis,
  - Partial/day treatment care,
  - Support for homeless mentally ill,
  - Alternative non-hospital placements for children/adolescents and adults,
  - In-school and day treatment services for children/adolescents,
  - Culturally appropriate services.
- Oahu:
  - Outpatient services for individuals with dual diagnosis,
  - Early identification/intervention opportunities for both adults and children/adolescents,
  - In-school and community-based prevention including greater provision of after-school programs
  - Substance abuse services geared for the elderly and youth.

The neighbor island communities noted that the lack of transportation on the neighbor islands and the cost of transportation between the islands makes it difficult for individuals to access services.

For all Hawai`i's communities, additional behavioral health services for those incarcerated would deter recidivism; more gender-specific chemical dependency treatments would better address the needs of female substance abusers; and more community-based adolescent chemical dependency services would better meet the needs of Hawai`i's youth.

Communities identified two important training needs. The first is a need for behavioral health and primary health providers to be trained in both mental health and substance abuse, and the importance of integrating behavioral health with primary care treatment. Cultural diversity training was noted as the second training need.

D. Priorities

Priorities for new or expanded behavioral health services in Hawai`i include:

- Address at least one of the gaps in services identified by the community groups.
- Demonstrate how the new or expanded services are going to be integrated with other health and human services.
- Be accessible, by design, to the populations identified as at-risk by the community in which services are to be provided.
- Be cost effective in service delivery.
- Reflect an efficient use of resources in meeting a community service need.
- Be designed to measure and report on the outcomes noted in Section B. above.

NOTES

[1] SAMHSA (Substance Abuse and Mental Health Services Administration). 1995. *Substance Abuse and Mental Health Statistics Sourcebook.* Publication No. (SMA) 95-3064. Washington, DC: U.S. Government Printing Office.
[2] State of Hawai`i, Department of Health, March 1997
[3] Vital and Health Statistics, Center of Mental Health Services, 1995
[4] Vital and Health Statistics, Center of Mental Health Services, 1995
[5] Office of Instructional Services. *1995 Hawai`i Youth Risk Behavior Survey Report*. Department of Education, June 1996.
[6] InnerVIEW Hawai`i
[7] Vital and Health Statistics, Center of Mental Health Services, 1995
[8] Vital and Health Statistics, Center of Mental Health Services, 1995
[9] Vital and Health Statistics, Center of Mental Health Services, 1995
[10] DOH/ADAD, 1995 & 1996
[11] Hawai`i Adolescent Treatment Needs Assessment Results from the Hawai`i Students Drug Use Study
[12] 1996 Hawai`i Student Alcohol and Drug Use Survey. Hawai`i Department of Health Alcohol and Drug Abuse Division.
[13] 1995 Adult Household Survey of Substance Abuse and Treatment Needs. Department of Health Alcohol and Drug Abuse Division.
[14] 1993 Youth Risk Behavior Survey, *Ke Ala Hoku Critical Indicators Report* 1997-1998
[15] 1996 Hawai`i Student Alcohol and Drug Use Survey. Hawai`i Department of Health Alcohol and Drug Abuse Division.
[16] Office of Health Status Monitoring. 1995 Behavioral Health Risk Survey Study. Hawai`i Department of Health.
[17] US Department of Transportation's Bureau of Justice Statistics, Drugs & Crime Facts, 1992
[18] Adult Mental Health Division, *Implementation Report of the State Plan for Mental Health*, 1996. and Alcohol and Drug Abuse Division, *State Plan, 1994-1997* and CAMHD, *CASSP Principles of Care*, 1996 .
[19] Ibid.
[20] SHPDA Reports, 1993-1994; SHPDA SAC minutes, 1998.